families are seeking help. Our WATCH IT community based programme in Leeds has 65 children enrolled with good attendance and we now have a waiting list.

Rather than dismiss the idea of screening at some point in the future, let us argue for more resources to develop clinically effective interventions.

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Patterns and risks in spinal trauma: the emergency transport perspective

The article by Martin and colleagues[1] reviewing patterns and risks in spinal trauma highlights the increased incidence of spinal cord injury (SCI) and spinal cord injury without radiological abnormality (SCIWORA) in young children. They suggest that without clinical suspicion proper evaluation of the child's spine may not occur, and refer to an audit by Skellet and colleagues[2] that shows inadequate spinal immobilisation of paediatric trauma patients on arrival of the paediatric retrieval team.

Preventing secondary injury during transfer (movement of patients between hard surfaces in close proximity) and transport (patient movement between facilities) is particularly important.

There are a number of devices available to facilitate spinal immobilisation during transfer and transport. These include spinal board (SB), vacuum mattress (VM), patslide, and scoop device in combination with traditional hard collar, blocks, and tapes to provide cervical spine immobilisation

We carried out a survey to identify the current practices in immobilisation, transfer, and transport of the paediatric trauma patient with actual or potential SCI. Postal questionnaires were sent to the retrieval coordinators in 18 UK paediatric ICUs asking about methods of spinal immobilisation during transfer and transport of paediatric trauma patients and existence of guidelines for management of that population.

There was a 100% response rate (postal plus follow up phone calls to two centres). Only 27% (5/18) of retrieval services employed practice guidelines. For patient transfer, 27% (5/18) of retrieval services utilised a patslide device alone and 50% (9/18) utilised a patslide in combination with a vacuum mattress and/or spinal board (table 1). For patient transport, 67% (12/18) of services had a consistent approach (table 2). A spinal board, either alone or with padding, was used by 72% (13/18) of services for at least some of their patient transports.

One hundred per cent of services used the traditional triad of hard collar, sandbags/blocks, and tape/straps for maintaining cervical spine immobilisation.

As Martin *et al* have described, SCI and SCIWORA occur more frequently in younger children. Without an obvious radiological abnormality, these injuries may potentially be overlooked. Prevention of secondary injury is thus important during transport of at risk patients. Our survey illustrates that there is a lack of a consistent approach to spinal immobilisation during transfer and transport of paediatric trauma patients. There is also continuing use of spinal boards despite evidence that they should only play a role during extrication of patients in the prehospital setting[3] and that vacuum mattresses may confer benefits in terms of patient safety and comfort.[4]

Table 1 Methods of patient transfer (n = 18)

	No.
Patslide alone	5
Patslide + VM	1
Patslide + SB	4
Patslide + VM or SB	4
Scoop + SB	2
VM alone	1
SB alone	1

Table 2 Methods of patient transport in services with a consistent approach (n = 12)

	No.
VM alone	4
VM + SB	1
SB alone	2
SB + padding	4
Trolley only	1

The development of best practice guidelines may lead to a more consistent approach.

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Dapsone therapy for Henoch-Schönlein purpura: a case series

Henoch-Schönlein purpura (HSP), first recognised by Heberden in 1801, is a systemic, IgA mediated vasculitis of small vessels that is usually self-limiting but may progress to gastrointestinal bleeding, intussusception, and nephropathy. A third of patients will experience recurrences.[1] Currently treatment is confined to rest, analgesia, and steroids for refractory abdominal pain,[2] and immunosuppressants for complications, especially renal disease. Original reports, predominantly in adults, show that the symptoms of purpuric rash, abdominal pain, and arthritis in HSP respond to treatment with dapsone.[3–5]

Even though the first case of HSP treated with dapsone was reported in 1983, it is still not generally recognised as a treatment for HSP. We describe eight children in whom, because of the severity or persistence of their symptoms, treatment with dapsone was commenced from among 41 patients diagnosed with HSP from January 1992 to May 2004. All gained a clinical response from treatment with the most beneficial effect on the skin rash. The demographic characteristics of the patients and their presenting clinical features as well as treatment are shown in table 1. The rash improved within 3 days to 1 week of starting treatment with dapsone in all patients. Six of eight relapsed when treatment was stopped, but responded again to treatment. The side effects are dose related and uncommon at doses commonly used (1–2 mg/kg daily).

Dapsone, an antileprotic drug, used for a variety of dermatological conditions, appears to be of special value in diseases characterised by accumulation of neutrophils, notably with leucocytoclastic vasculitis, of which HSP is an example. There is evidence that it has antioxidant scavenger effects and may suppress the generation of toxic free radicals in neutrophils. It also inhibits prostaglandin D2 production and synthesis of IgG and IgA antibodies.[6] It may also inhibit IgA–neutrophil interactions.[3] Given the pathogenesis of HSP with IgA mediated vasculitis, treatment with dapsone represents an exciting form of treatment. The clinical course of our patients suggests that dapsone controls the cutaneous vasculitis rather than cures it. As steroids may mask the features of more ominous intestinal disease, dapsone can be a reasonable alternative. Nonetheless, to date there is no evidence of a positive effect on renal disease.

In conclusion, dapsone is a drug that may have a role in the treatment of HSP. In order to establish its usefulness it is necessary to conduct a multicentre, placebo, randomised controlled trial.

Informed consent was obtained from parents before starting treatment with dapsone.

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Table 1 Demographic characteristics, presenting clinical feature, and treatment of the patients

	Patient							
	1	2	3	4	5	6	7	8
Age at presentation	22 m	8 y	8 y	5 ½ y	10 y	5 y	8 y	10 y
Sex	F	F	F	M	F	F	M	F
Race	White	White	White	White	White	White	Vietnamese	White
Prodrome	−	Sore throat	−	−	Diarrhoea	Pustules	−	Tonsillitis
Presenting features								
Miserable	+	−	−	−	−	−	−	−
Rash	+	+	+	+	+	+	+	+
Joint pain	−	+	+	−	+	+	−	+
Joint swelling	+	−	+	−	+	+	−	−
Abdominal pain	−	−	+	+	−	+	+	−
Vomiting	−	−	−	+	−	+	+	−
Swollen testicle	−	−	−	+	−	−	−	−
Haematuria	−	+	+	−	+	−	+	+
Proteinuria	−	+	+	−	−	+	+	−
Rectal bleeding	−	+	−	−	+	−	−	+
Length of presentation	1 d	2 d	2 d	1 d	5 d	4 d	5 d	1 d
Presentation to treatment	10 d	14 m	4 m	18 m	5 d	8 d	11 d	1 m
Dose	1 mg/kg od	1.3 mg/kg od	1 mg/kg od	1.25 mg/kg od	0.75 mg/kg bd	1 mg/kg od	1 mg/kg od	0.5 mg/kg bd
Length of first course	6 d	7 d	4 d	4 w	10 d	7 d	14 d	10 d
Positive response	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Relapse after first course	No	Yes	No	Yes	Yes	Yes	Yes	Yes
Total duration of treatment	6 d	7 d	4 d	2 ½ y	8 m	5 w	5 w	2 y

d, day; w, week; m, month; y, year; +, present; −, absent; od, once a day; bd, twice a day.

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If community paediatricians did not exist, it would be necessary to invent them

Since 1991 there has been talk of abolishing community paediatrics as a specialty.[1] At that time, a group of related specialties was proposed: a specialty of child development and rehabilitation (neurodisability); child protection would be subsumed into general paediatrics and there would be child public health doctors. Since then there has been a view among some paediatricians that community paediatricians should become the general paediatricians of the future.[2 3] Dr Chambers' recent article proposes a narrow view of community paediatrics, concentrating on chronic illness and confining its role to diagnosis and medical management.[4] He rather misses the point.

The challenge of community paediatrics

Children do not come in neat packages, with diagnostic labels. They and their families need all their needs met. Hospital practice traditionally concentrates on the illness, not the patient, although this is becoming less with time and paediatricians have always been more holistic than adult counterparts. Hospital practice often deals with complex problems by having specialists for each problem. Our adult physician colleagues are beginning to realise that doesn't work and are reinventing the general physician.

It has been shown that community paediatric patients have significantly more complex problems than those presenting to general paediatricians.[5] Many of the conditions we diagnose and treat have no diagnostic tests. Community paediatricians need excellent clinical skills, must be able to manage complexity and uncertainty, and must have the ability to communicate across disciplines and across agencies, creating understanding in those who come from different backgrounds and with different agendas. It is not an easy job.

The National Service Framework

The NSF was constructed by multidisciplinary groups including parents. It is therefore no accident that child health, not illness, is emphasised. Hospital practice has rather less emphasis than crosscutting ''out of hospital'' issues. Communication, coordination, and early intervention are all key themes. Parents and our sister agencies value medical input that is holistic, available where it is needed (not just in the clinic), and attuned to the needs of the child and family in the community. They demand more of it than we can currently give. Nevertheless, child health outside hospital has moved up the agenda and it will be hard for local authorities to deliver Every Child Matters without focused child health support to education, social, and voluntary services, as well as child health per se. This new agenda requires exactly the skills community paediatricians have. If community paediatricians did not exist, it would be necessary to invent them to deliver the NSF. The challenge is how we tackle it.

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Competing interests: Dr Ni Bhrolchain in a Specialty Training Advisor in Community Child Health. These views are her own.

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Melatonin: a panacea for desperate parents? (Hype or truth)

Sleep disorders are common in children with neurodevelopmental disorder and are a major source of stress for the whole family. In children with neurodevelopmental disabilities the prevalence may be as high as 80%.[1] The current literature is suggestive of circadian rhythm dysfunction, social difficulties, and abnormal melatonin levels in children with autism.[2]

Hypnotics and sedatives can produce side effects and tolerance,[3] so is melatonin the answer in children with sleep problems associated with severe developmental difficulties of social and communicating nature, which have not responded to behavioural and social measure? Previous studies and case reports have suggested that melatonin could be effective.

We retrospectively reviewed cases of nine autistic children with chronic sleep disorder, who were attending the Child Developmental Centre at Windmill Lodge. The age range of these children was 2–11 years. No additional non-pharmacological sleep intervention was instituted. They were started on 2.5–5 mg melatonin 45 minutes before their sleeping time. In four of these patients sleep latency was reduced. Our own experience of reduction in sleep latency is in accordance with literature.[4] Five parents reported improvement in total duration of sleep. In