The management of childhood diabetes needs to focus not only on glycaemic control but also on efforts to prevent excessive weight gain and to reduce other cardiovascular risk factors.

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ESPE/LWPES Consensus Statement on diabetic ketoacidosis in children and adolescents (*Arch Dis Child* 2004;89:188–94)

Given the fact that patients with type 1 diabetes have a life-long predisposition to recurrences of diabetic ketoacidosis, it is remarkable that the approach to the management of this complication is taught in a fundamentally different way in paediatrics and in adult medicine. In the former, the primary aim is to eliminate ketonaemia and ketonuria expeditiously, using a fixed dose and evidence based insulin infusion, namely, 0.1 unit/kg/h,[1] which is maintained as long as necessary even if it entails the risk of hypoglycaemia, the latter eventuality being circumvented through the infusion of intravenous glucose, given the fact that the resolution of acidaemia takes longer than the normalisation of blood glucose concentrations.[2]

The teaching in adult medicine, conveyed through the medium of the handbook most likely to be used by junior doctors, is that normalisation of blood glucose is paramount, hence the preoccupation with a sliding scale insulin regime targeted at the blood glucose,[3] as opposed to a fixed dose regime targeted at ketonaemia and ketonuria.

What this means is that, in the transition from childhood to adulthood, a diabetic will encounter a change in emphasis during the management of recurrences of ketoacidosis . I am not sure that this is right.

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Soy formulas and hypothyroidism

We were interested in a recently published article in *Archives* by Conrad and colleagues.[1] They concluded that infants fed soy formula had a prolonged increase of thyroid stimulating hormone when compared to infants fed by non-soy formula. We have some criticisms of their study methods.

In this retrospective study there was a notable difference between the patient numbers in the soy diet group (n = 8) and non-soy diet group (n = 70). It is well known that in prospective studies in which data of two groups are compared, in order to gain statistically significant results there should be a minimum of 10 test subjects in each group and the numbers in the groups should be close. Although it is not essential to follow this rule in retrospective studies like the one of Conrad *et al*, the statistical reliance of the study fails since the soy diet group has eight patients whereas the other one has 70.

Secondly, in studies in which comparisons of any of body fluid parameters are made for each group, for better results, it is important that the materials must be studied in the same sessions using calibrated machines after the materials have been stored appropriately. This could not be achieved since the study was retrospective, and it is therefore inevitable that there were differences between the thyroid stimulating hormone and thyroxine results of the soy diet and non-soy diet groups. For these two reasons we think it is impossible to conclude that soy formula decreases the success of treatment in congenital hypothyroidism. We believe that further prospective controlled studies can better shed light on this topic.

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Evidence based guideline for post-seizure management

Following the publication of the guideline review ''Evidence based guideline for post-seizure management in children presenting acutely to secondary care''[1] we would like to clarify the following.

First, the guideline is published in its original algorithm format in a peer reviewed journal[2] as well as being available on the PIER website (www.pier.shef.ac.uk), complete with minor changes following the updated systematic review in 2002.

Second, the guideline was not published until it had been assessed with regard to ease of use and clinical impact. The findings of this large scale field study show its effectiveness in improvements in quality of care and are also published.[3]

Third, the original guideline was developed by The Paediatric Accident & Emergency Research Group, and represents many years of work. The individuals and affiliations at the time of the research are as follows:

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Ethics; the third dimension

In essence, ethics provide the guidelines for civilised human interaction. It is an evolving concept, but through the ages some accepted ethical principles crystallised. The first crude definition focused on the individual's responsibility towards his community, prioritising the interests of the community. However, the events preceding the French revolution and the brutality of the two world wars emphasised the need to protect individuals and minority groups against abuses of power. The ethical focus shifted from individual responsibility towards the protection of individual human rights. With the swing of the pendulum, individual rights were often protected to the detriment of the larger community.

In medicine the same shift in emphasis forced the current ethical debate on the delicate balance between the interests of the individual and that of the community, especially in resource limited settings. The reality of the third millennium is that all the world's inhabitants are essentially part of the same global community. The two dimensional balance between the individual and the community need to reflect this global ethical responsibility.

The third millennium also confronts us with the neglected third dimension of our ethical responsibility. It is not only the interests of the individual versus that of the community that

require a fair balance, but also the interests of future generations. No previous generation has been confronted with the importance of this third ethical dimension, as we have. Although current decisions may impact dramatically on the health of future generations, this has not entered into popular medical conscience or current ethical debate. As medical doctors the health of future generations is as much our ethical responsibility as the health of our individual patients or our immediate community.

Environmental issues are rarely viewed as medically relevant, but can the medical profession accept this status quo, when the health of future generations is at stake? The third millennium demands a broadened ethical perspective, where established ethical principles are applied, but within the setting of a global community and a vulnerable planet.

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Splenectomy in cystic fibrosis patients

A recent article,[1] a commentary,[2] and two letters[3 4] in *Archives* have revealed controversy over the place of partial splenectomy in portal hypertension in cystic fibrosis (CF). We wish to contribute to the debate with a case report:

Our male patient was homozygous for the ΔF508 mutation. He was pancreatic insufficient, his lungs were colonised with *Pseudomonas aeruginosa* from an early age, and he had two episodes of allergic bronchopulmonary aspergillosis. When he was 8 years old, abdominal ultrasound showed variable echogenicity of the liver compatible with cirrhosis with thick bile in the biliary tree. Treatment with ursodeoxycholic acid was commenced. Recurrent abdominal pain associated with severe gastro-oesophageal reflux led to an anti-reflux procedure being performed when he was 9 years old. A gastrostomy button was placed at the same time for night time supplementary feeding. Cirrhosis of the liver was confirmed intraoperatively. Over the next few years a massive splenomegaly developed. Full blood count showed features of hypersplenism but he remained asymptomatic with respect to the haematological abnormality. At the age of 13 years he developed severe abdominal pain in the area over the spleen. Oral analgesia was not sufficient to deal with this ongoing pain and he was unable to attend school, exercise, or do chest physiotherapy over a number of months. He had two episodes of probable melaena. He developed severe, intercurrent shoulder tip pain secondary to diaphragmatic irritation from splenic infarcts. Computerised tomography of the abdomen showed the spleen's span to be 30 cm, with two infarcts. Opiates were given to control pain but it proved to be intractable in an otherwise stoical patient. Eventually, because of the risk to his lungs, his poor quality of life and the risk posed to his gastrostomy by the massive spleen, partial splenectomy and possible splenorenal shunting were planned. Pneumococcal vaccine was prescribed. His white cell count (WCC) was 1.5×10^9/l, platelet count 58×10^9/l, and INR 1.6. At laparotomy, perisplenitis in the diaphragmatic area necessitated a total splenectomy. Shunting was not undertaken. The spleen weighed 1834 g and there were numerous infarcts. Postoperatively he did well, patient controlled analgesia being used to encourage early mobilisation. Eight days later elective banding of oesophageal varices took place. Follow up endoscopy showed that this had ablated all the vessels. Two years later he no longer has abdominal pain, has not had severe infections, has a normal full blood count (WCC 12.3×10^9/l, haemoglobin 141 g/l, platelets 486×10^9/l), and has stable lung function.

The debate on the justification for removing all or part of the spleen in patients with CF and portal hypertension hinges on two considerations: indications and risks In their commentary, Kelly and de Ville de Goyet[2] emphasised the risks: infection, compromising future transplantation, while questioning the indications in the cases presented by Thalhammer *et al*: hypersplenism and discomfort.[1] In their rebuttal, Thalhammer and colleagues[3] emphasise the hypersplenism and not the pain and discomfort described in their case reports. In their accompanying letter, Chazalette and colleagues[4] do not mention pain as an indication. We would agree with Kelly and de Ville de Goyet[2] that hypersplenism in the absence of significant consequences is not on its own an indication for this major procedure (we note the number of re-laparotomies required in these small series) but would emphasise that quality of life and local effects of the size of the spleen may justify the surgical and immunological risks.

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Think laterally!

I wish to emphasise the importance of thinking laterally while looking at skin marks in at-risk children in the setting of a child protection medical, especially under the present medicopolitical climate where paediatricians are being blamed for ''doing too little'' and ''doing too much''.

I was asked to see a 6 year old child with learning disabilities for a child protection medical by Social Services. He was under a care order because of issues regarding neglect. He was, however, living unsupervised with his parents.

The alarm was raised by his school teacher who noted a large red mark on the back of his neck and shoulder for which apparently he could not give a logical explanation.

On examination he indeed had a geographical area of redness on his skin from the back of his neck down to the right armpit. There were drip marks. I did not get a coherent explanation for the mark from the little boy. I initially interviewed him without his parents being present on Social Services' request. However, because of the child's obvious learning difficulties I asked mum to come in towards the end of the interview and went through the history with her. She denied all knowledge of him having sustained an injury in the last few days.

I tried to wash off the skin mark with water and tissue, in front of the mother and the social worker, with no effect.

I therefore told mum and the social worker that I was not sure as to the origin of the mark. It did not have any characteristics of any particular injury nor was it something that could be washed off. I told them that I needed to observe him overnight to see if it evolved into anything (there was a significant amount of pressure from the social worker not to let him go home that night as well).

I documented my thoughts in the notes very clearly and never suggested that I suspected non-accidental injury.

The next morning the entire skin discolouration washed off with soap and a scrub! Mum was extremely upset with the whole situation and wanted to talk to me. She at that point disclosed that he was drinking a soft drink called ''Vimto'' which was quite dark red in colour. She was also upset that we had kept him in on suspicion of ''abuse''.

I was able to placate her by reading out my documentation that clearly said that I was not sure of the origin of the mark and I could not draw any firm conclusions from it.

This just highlights the sort of pressures that can be brought to bear from various quarters on a consultant paediatrician dealing with child protection medicals. It also highlights the need for us to be vigilant about simple things which can give rise to very suspicious looking skin marks. And lastly, perhaps most importantly, it highlights the extreme importance of honest, clear, unequivocal, contemporaneous notes, as this is what stopped this situation from becoming a risk management and complaint issue.

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Rib periosteal reaction: did you think about chest physical therapy?

Rib fractures are uncommon in infants. Child abuse must be suspected, especially when location is posterior, as explained by the lever phenomenon.[1] The positive predictive value of rib fractures as an indicator of abuse is 95–100%.[2] Bone fragility diseases, severe cough, and cardiopulmonary resuscitation can cause rib fractures, and chest physical therapy (CPT) has only been mentioned in a recent retrospective series.[3]

From May 2000 to May 2003 we prospectively collected chest radiographs performed as a workup for bronchiolitis, and collected six cases of infants less than 2 years old for