with CSII, to 7.81% (SD 0.95) 12 months later (paired *t* test: $p = 0.002$). In addition, the mean daily insulin requirement of the patients dropped by 23.7%, from 58.2 IU (SD 15.3) to 44.4 IU (SD 11) (paired *t* test: $p < 0.001$); the mean body mass index did not vary significantly in the period (from 20.7 (SD 2.5) to 21.2 (SD 2.4)). During the period studied no episodes of hypoglycaemia occurred; one episode of ketoacidosis was caused by displacement of the cannula. No episode of local infection occurred. Three patients discontinued the CSII after the first year and one after the second year of treatment.

Our experience shows that use of an insulin pump improves the metabolic control of T1DM in children and adolescents, and reduces the daily insulin requirement.

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Read the label carefully

The figure shows the packaging of a ''rice slice'', which a mother gave to her 23 month child, believing it to be free of any milk. The patient had an anaphylactic reaction shortly after ingesting a very small amount. On close inspection of the ingredients, casein is listed but not qualified as a milk protein.

The child initially presented at 8 weeks of age with a cutaneous reaction to cows' milk formula on her second exposure, having previously been breast fed. She had raised specific IgE level to milk and a positive skin prick test (3 mm wheal with 6 mm erythema). Thereafter she was managed with an extensively hydrolysed formula and the family were given advice to avoid all milk and its derivatives. They were prescribed antihistamine but not an adrenaline auto-injector.

This case illustrates the difficulty of managing allergy in real life. It is easy to see how a product described as a ''delicious alternative to cheese'' could be wrongly thought to be milk free unless the ingredients are closely scrutinised. Thirty per cent of children diagnosed as allergic have been shown to have a further exposure in the year after diagnosis.[1] A further difficult issue in clinical practice is when to prescribe adrenaline, especially for the youngest patients in whom

there is no proprietary device in the correct dose for size.[2]

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Board senseless

The ward patient name board is a familiar sight, placed prominently on most hospital wards. Concerns regarding guidance on patient confidentiality,[1] stemming from the Caldicott report,[2] led our trust to remove the boards from the general areas of the paediatric wards. They were placed in a less public area—generally the treatment room. It led to delays in staff being able to identify a child's location and their nurse's identity, and general dissatisfaction among the clinical teams.

The parents of 20 patients (age range 11 months to 13 years) on our regional paediatric oncology ward completed a questionnaire. Parents who had only recently received the diagnosis were excluded. Parents responded to five statements, with ''strongly agree, agree, disagree, strongly disagree, or neither''.

(1) *I object to having my child's name and location on the board where everyone else can see it*—17 disagreed (11 strongly), with 1 parent agreeing.

(2) *I think that having the centrally placed name board helps the people looking after my child to quickly find out where my child is and who is looking after them*—19 agreed (14 strongly), with 1 disagreeing.

(3) *I think having my child's name on the board represents a risk to their safety*—18 disagreed (11 strongly), with no parents agreeing.

(4) *I like to be able to look at the board to see which other patients whom we know are on the ward*—18 agreed (13 strongly), with no disagreement.

(5) *I would be happy for the name board to be reintroduced*—19 agreed (15 strongly) with no disagreement.

Armed with these results, and mindful of various comments made by parents, the boards are back to their original place. On admission, the parents are asked whether they object to their child's full name being placed on it. This appears to work well, with satisfaction among clinicians, parents, and managers—an unusual state of affairs!

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CORRECTION

The authors of the paper entitled Epidemiology of paediatric renal stone disease in the UK (Coward *et al, Arch Dis Child* 2003;**88**:962–965) would like to acknowledge the source of their data in Table 1. This table was adapted from data published in the paper by So *et al* (Pediatr Nephrol 2001;**16**:133–139).