PostScript

LETTERS

Effects of probiotics on atopic dermatitis

I was amazed to read the positive tone of the discussion in a recent article published in your journal which concluded that supplementation with a probiotic is beneficial in improving the extent and severity of atopic dermatitis in young children.¹ This was despite the fact that the data clearly showed no significant difference in improvement between the placebo and treatment groups. The result that was discussed at length was the significant difference before and after probiotics in the treatment group without taking into account the placebo group. Why construct such a careful randomised double blind placebo controlled trial and then completely disregard the control group when drawing conclusions? I could find no support for the editorial statement that “probiotics may indeed provide benefit in infant eczema” from this study.

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Competing interests: none declared

Reference

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Importance of the infant death scene investigation for accurate and reliable reporting of SIDS

Inaccurate classification of the cause and manner of infant deaths impedes prevention efforts by limiting researchers' ability to accurately identify risk factors for SIDS and other sudden, unexpected deaths in infancy (SUDI). Sheehan and colleagues¹ present evidence of inaccurate reporting of SIDS in Ireland and underscore the necessity for standardised SUDI criteria and definitions, as well as a multi-disciplinary approach to improve the diagnostic reliability of SUDI cases. Two recent US studies also provide evidence that cause-of-death reporting for SUDI may be unreliable by demonstrating that the decline in the SIDS rate since 1999 is offset by increasing mortality rates for cause unknown/unspecified and accidental suffocation and strangulation in bed.^{2,3}

We agree with Sheehan and colleagues' approach for improving the accuracy of SUDI reporting.¹ In addition, we believe it is imperative that a thorough death scene investigation be conducted before a death can be classified as SIDS. Studies have presented evidence to support the contention that SIDS and other SUDI are more accurately diagnosed when information from a death scene investigation is used to make the diagnosis.^{4,5} A thorough infant death scene investigation should at a minimum include interviewing witnesses, examining the death scene, staging a doll reenactment, reviewing medical history, and carefully assessing the infant's exposures prior to death.

To improve the accuracy and consistency with which SUDI are classified, the Centers for Disease Control and Prevention (CDC) is leading

a US effort to develop standards for the conduct of infant death scene investigations. We are developing training curricula and materials to instruct those investigating and certifying infant deaths on how to gather information at the scene and use the data to interpret postmortem examination findings. This training will help ensure that accurate and consistent diagnoses of SIDS and SUDI are made.

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References

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Adenosine dosing in supraventricular tachycardia: time for change

We read with great interest the article by Dixon *et al* on the dosing of adenosine in supraventricular tachycardia (SVT).¹ We have recently reviewed cases of SVT presenting to the Children's Heart Unit of Wales with a special focus on the effective dose of adenosine, and have made disturbingly similar observations. Our findings were recently presented at a research society meeting.

Over a period of 10 years a total of 137 infants and children presented to our unit with a diagnosis of SVT. Of these adenosine was used in 37 cases on 70 occasions. Throughout South Wales the Advanced Paediatric Life Support (APLS) guidelines for adenosine are followed, which suggest incremental doses of 50 µ/kg, 100 µ/kg, and 250 µ/kg for the acute management of SVT.

The recommended starting dose of 50 µ/kg was effective only on four occasions—that is, in less than 6% of the cases. The second dose was effective on another 33 (47%) occasions, while the third dose of 250 µ/kg successfully terminated the arrhythmia in another 24 (34%) cases. Adenosine was ineffective on 9 (13%) occasions. Other agents were required in these cases. The mean effective dose of adenosine thus works out to be 156 µ/kg.

Our findings support the conclusions of Dixon *et al* that the current recommended adenosine doses for acute management of SVT are ineffective in the vast majority of cases. This highlights the urgent need for review of the dose protocol of adenosine in SVT.

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Reference

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Computed tomography in miliary tuberculosis

Computed tomography (CT) is used to diagnose mediastinal lymphadenopathy when patients with suspected pulmonary tuberculosis (PTB) present either with normal chest radiographs¹ or with non-specific pulmonary infiltrates.² It may also have a role in: (1) establishing the diagnosis of miliary tuberculosis (MTB) when chest radiography shows a non-specific interstitial pattern³ (which may be erroneously attributed to *Pneumocystis carinii* in HIV infected patients); and (2) establishing the diagnosis of MTB when chest radiography has failed to detect any parenchymal abnormality. In the former instance the resulting diagnostic confusion can be resolved by use of CT.⁴ In the second scenario, CT has been reported to show MTB even when near-contemporaneous chest radiography shows no abnormality (with an imaging interval of 3–7 days⁵ or only one day⁶), or when a truly contemporaneous chest radiograph shows only mediastinal lymphadenopathy (parenchymal miliary nodules having totally escaped detection by chest radiography even after two months' follow up).⁷

There is a significantly higher prevalence of CT diagnosed miliary tuberculosis ($p < 0.01$) among HIV-seropositive than among HIV-seronegative subjects with PTB.⁸ Although the use of chest radiography in diagnosis is limited (the sensitivity for detection of MTB is, at most, 69%),⁹ its use nevertheless yields a significantly higher prevalence of MTB ($p < 0.001$) among HIV infected patients with tuberculosis than among those in whom tuberculosis is not associated with HIV infection.¹⁰ In the days before CT and the HIV/AIDS era, 14 out of 224 children with miliary tuberculosis died without the correct radiographic diagnosis having been made because miliary tubercles had escaped detection by chest radiography.¹¹ The clear message from the HIV/AIDS era is that all doctors dealing with suspected PTB should have a heightened suspicion for miliary tuberculosis. Guidelines for the “work up” of these patients should highlight the role of CT and the importance of its early involvement in the diagnostic process.

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