Medline, The Cochrane Library, the BNF/Children's BNF, Epilepsy Action website, and The National Society for Epilepsy website found no mention of or reference to a need for a "test dose". The Joint Epilepsy Council of the UK and Ireland has recently published *A guideline on training standards for the administration of buccal midazolam*.⁴ This document "recommends that a test dose of midazolam be administered in hospital. Although this is at the discretion of the prescribing medical practitioner, we would endorse for patients with a medical history of respiratory problems or a previous adverse reaction to benzodiazepines". No references or other evidence are provided to support this recommendation.

Some paediatric neurologists recommend a test dose, others do not. A survey of paediatric neurologists in 2003 revealed that 49% disagreed or strongly disagreed with giving a test dose of midazolam, 34% were neutral, and 17% agreed with giving a test dose. Of those prescribing buccal midazolam, only 33% used a test dose in hospital.³

We have recently undertaken a survey of paediatricians selected from the RCPCH handbook. Fifty five questionnaires were sent to districts with representation in all British regions. Twenty six responses were received (47% response rate). Four of 26 (15%) did not use buccal midazolam. Four of 22 (18%) routinely used a test dose in hospital for "safety reasons", "to teach carers", "to provide reassurance to parents", and "because local paediatric neurologists recommended it". Eighteen of 22 (82%) did not use a test dose; reasons given were that "midazolam is as safe as diazepam", "it is unethical to give a test dose in circumstances which do not replicate its use in clinical practice", "local paediatric neurologists do not recommend a test dose", "a test dose is not recommended in the Children's BNF", and that "there is no evidence base for a test dose". Two of 22 use midazolam intravenous solution, 18/22 use Epistatus oral solution, and 2/22 use both preparations.

There are persuasive reasons to use buccal midazolam but few to recommend a test dose. Most paediatric neurologists and paediatricians do not recommend a test dose. Is it time for those of us continuing this practice to stop?

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NICE guidelines for hyperlipidaemia in children and young people with type 1 diabetes: time for a rethink?

Both diabetes mellitus and hyperlipidaemia are recognised risk factors for atherosclerosis. Postmortem studies show that aortic and coronary atherosclerosis is commonly seen before age 20 years. Hyperlipidaemia is correlated with the extent of early atherosclerotic lesions in adolescents and young adults.^{1,2} Despite this, the current NICE guidelines recommend that screening for children with type 1 diabetes is not indicated.³ The arguments put forward are that screening in adulthood may be just as effective and that further dietary intervention in young people with diabetes would be unwelcome. The American Diabetic Association, however, recommends the screening of all pubertal children (>12 years) at diagnosis; for pre-pubertal children, they recommend screening only if family history is of concern.⁴

Since 2000, our local policy was that all patients would be screened for hyperlipidaemia annually (non-fasting samples). Abnormal results (total cholesterol >5 mmol/l or triglycerides >2.4 mmol/l) are repeated with fasting samples. Persistent hyperlipidaemia is managed conservatively by improving glycaemic control, physical exercise, and advising on dietary changes. Pharmacological management of hyperlipidaemia is reserved for severe forms. We retrospectively analysed data for all patients with type 1 diabetes attending our clinics between January 2000 and March 2005.

There were 147 patients (75 male). Mean age was 11.2 years (range 2.0-19.1). According to protocol, there were 492 screening opportunities but only 421 screens were performed (83.5% compliance with protocol).

Twenty two patients (14.9%) had persistent hyperlipidaemia. Table 1 shows their diagnoses. Two patients required pharmacological treatment; the rest were managed conservatively. Twenty one patients with hyperlipidaemia were also poorly controlled diabetics with HbA1c >8%.

Routine screening for evidence of dyslipidaemia led to the diagnosis of clinically important conditions, in our cohort, for which further management was possible. Selective screening, as suggested by the ADA, would not have led to any significant delay in the management of these patients and may be an acceptable compromise.

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BOOK REVIEWS

Child and adolescent neurology, 2nd edition

Edited by Ronald B David. London: Blackwell, 2005, €79.50 (US\$140 (approx.)); €115 (approx.), hardback, pp 638. ISBN 1405117672

Current management in child neurology, 3rd edition

Edited by Bernard L Maria. Ontario: B C Decker, 2005, \$169.95 (£95 (approx.)); €140 (approx.), hardback, pp 687. ISBN 1550092928

Perhaps 15-20% of hospitalised children have a neurological problem. There are not enough paediatric neurologists to see them all in the UK or in many other countries including the USA and Canada. So we generalists need to recognise common neurological conditions, keep up with modern treatments of simpler problems, and know when to refer the more complex. These two substantial volumes (2.0 and 2.3 kg, respectively) aim to provide "essential knowledge and collected wisdom" and to "provide

Table 1 Diagnoses of patients

Diagnosis	No. of patients
Dysbetalipoproteinaemia (type III hyperlipidaemia)	2
Familial hypercholesterolaemia	1
Membranous glomerulonephritis	1
Multifactorial hyperlipidaemia	16
Diagnosis unknown (transferred prior to full evaluation)	1