the week on call system; this consultant does not have outpatient clinics when on call for the wards. As this currently is on a 1 in 6 basis, there are an additional 7 or 8 weeks of clinics "lost" per year. It therefore becomes difficult for one consultant in a DGH to see all patients with epilepsy and seizures, especially as most consultants have other responsibilities and clinical skills in other areas to maintain—for example, on average we are also responsible for managing 700–800 acute admissions and 400 new outpatient referrals each year.

We agree with the concept of a paediatrician developing a specialist interest and service for children with epilepsy, who can also act as the representative on the regional network and be able to give a local second opinion on the more difficult cases, but this person probably may not be able to see all cases. What is vital, based on our own experience, to develop an integrated local epilepsy service is to have a nurse specialist in epilepsy. Although it may not be possible for one paediatrician to see all patients, it should be possible for a full-time epilepsy nurse to do so.

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Chest x ray and high-resolution computed tomography in cystic fibrosis

We read with interest the article by Jiménez *et al*¹ reporting the use of low-dose, high-resolution computed tomography (HRCT) in children with cystic fibrosis, and the excellent commentary from Langton Hewer² in the May issue. We agree with Langton Hewer's conclusion that although HRCTs provide an earlier and detailed insight into progression of cystic fibrosis-related lung disease, they offer limited advantages for patient management in the current therapeutic environment.

We carried out a study that supports these conclusions. We undertook a prospective, blinded comparison of ultra low-dose HRCT, chest x ray (CXR) and spirometry in 30 children (aged 5.02–17.35 years, 13 males) with cystic fibrosis when free of acute exacerbation. Scans were performed at 100 kV and 30 mAS. Slices of thickness 1 mm were taken at 10-mm intervals. These were presented for scoring as hard copy images with either the whole image dataset or alternate images (equalling 10-mm or 20-mm slice intervals). The CXRs and HRCTs were scored independently by two consultant paediatric radiologists using Mafessanti and Bhalla (HRCT) and Crispin–Norman (CXR) scores. Assuming a 20-mm slice interval, our dose calculations showed a total absorbed dose equivalent to two CXR examinations

(posteroanterior and lateral) for the ultra low-dose HRCT protocol.

Our results confirmed the validity of a low-dose limited slice technique (ie, 20 mm), and we concur with Jiménez *et al* with respect to the technical feasibility of this method in the sequential assessment of cystic fibrosis in children of school age. However, CXR scores and HRCT scores were in close agreement ($r = 0.9$) using either scoring system across the range of scores recorded. Although HRCT provided more detailed information about the characteristics of lung disease, CXR scores were as sensitive as the HRCT scores for recording the presence of the disease.

Although there was a good correlation between forced expiratory volume at 1 s and HRCT scores ($r = 0.6$), we did not identify useful spirometry parameters for the early detection of lung disease shown on HRCT and CXR.

Given the limited therapeutic options for presymptomatic cystic fibrosis lung disease, we suggest that routine low-dose HRCT is unlikely to considerably contribute to patient management in this age group. This might, of course, alter if novel therapeutic interventions for which changes in HRCT appearances are valid as a clinically relevant outcome parameter become available. Currently, CXRs provide a practical and adequately sensitive test for the routine assessments of respiratory status.

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doi: 10.1136/adc.2006.103903

Competing interests: None.

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Banning mobile phones in hospitals: is there enough evidence?

In an otherwise comprehensive review by Dr Wood¹ on the health risks of mobile phone usage, there was no mention of the mobile phone usage policies adopted by hospitals in the UK. Mobile phone use has escalated over the past decade, and to many people they are now an essential part of business, commerce and society. According to the OfTel Residential Survey carried out in May 2003, 75% of all adults in the UK owned or used a mobile phone.² The use of mobile phones and related technologies will continue to increase in the foreseeable future. Many hospitals in the UK ban the use of mobile phones in their premises. It is ironic that in this era of evidence-based medicine, there is not much evidence to support this practice. In fact, the Medicines and Healthcare Products

Regulatory Agency (MHRA), the committee to advise the Department of Health on these issues, does not support a blanket ban on mobile phones in hospitals.³ They suggest that all hospitals should identify the areas in which mobile phone usage might interfere with medical equipment—for example, intensive therapy units and special care baby units. Data from MHRA studies⁴ showed that only 4% of devices had interference from cell phones at a distance of 1 m, with <0.1% showing serious effects as compared with the observation that 41% of medical devices had interference from emergency radio handsets at a distance of 1 m with 49% of the responses being serious. MHRA classifies communication devices into three categories:

1. high-risk equipment such as private business radios mainly used by porters and maintenance staff, and analogue emergency service radios;
2. medium-risk equipment such as mobile phones, laptop computers, palmtops and gaming devices fitted with general packet radio systems; and
3. low-risk devices such as cordless phones (including digital European cordless technology).³

Physiological monitors or devices incorporating them, such as defibrillators or external pacemakers, were the most severely affected devices and for every device type, some models consistently performed better than average. Current policies adopted by most hospitals in the UK do not deal with the issues related to the use of palmtop or laptop computers, although an increasing number of health professionals rely on these devices for access to information portals. Hospital managements should recognise the fact that many people own mobile phones attests to their perceived importance to the general public, and efforts should be made to develop new evidence-based policies rather than enforcing a blanket ban on mobile phones so that the general public and health professionals can make optimum use of mobile technology without compromising patient safety.

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Competing interests: None.

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Changes in guidance for prescription of controlled drugs

The Shipman inquiry concluded that there were several shortcomings in the management system for controlled drugs (<http://www.the-shipman-inquiry.org.uk/home.asp>). As a result, changes to prescribing and

dispensing of controlled drugs are being introduced.

We are concerned that the implications, and possibly unintended consequences, of the new guidance have not been widely recognised or publicised to paediatricians and child psychiatrists.

We first became aware of changes to prescribing policy after several phone calls from local pharmacists refusing to issue more than 28 days supply of methylphenidate for our patients with attention deficit hyperactivity disorder, and so we sought further clarification.

Changes will be introduced, subject to parliamentary approval, in the summer of 2006. In some cases the changes will be effected through professional guidance, and in other cases through further amendment to the Misuse of Drugs Act Regulations (http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4131465&chk=qsfb19). The key issues affecting paediatricians are the following:

- Duration of any prescription for schedule 2 (eg, methylphenidate 2, which is a controlled drug), 3 and 4 controlled drugs should be restricted to 28 days.
- Introduction of 28-day maximum quantity on prescriptions for schedule 2, 3 and 4 controlled drugs.
- In future, prescriptions should be printed rather than hand written.
- Re-emphasis of professional guidance that doctors should prescribe controlled drugs for themselves or family members only in exceptional circumstances.

Clearly, it will have a huge effect on the paediatric prescribing workload if we had to issue monthly repeat prescriptions for all children on methylphenidate. Further discussion with The Department of Health showed that in exceptional circumstances where the prescriber believes that it is clinically indicated and would not pose an unacceptable risk to patient safety, a prescription for >28 days, may be allowed. It was suggested that the trust "Prescribing Lead" highlight the issue of methylphenidate with local pharmacies and that the issue of methylphenidate be specifically considered in the future.

In the short term, paediatricians need to be ready to justify their prescribing decisions and need to be aware that prescriptions for >28 days' supply may not be dispensed; they may then wish to invest in a departmental prescription printer!

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doi: 10.1136/adc.2006.104877

Competing interests: None declared.

Diagnostic value of skull x rays in infants with plagiocephaly

A national survey concluded that the management of deformational plagiocephaly

among paediatricians and neurosurgeons in the UK was very varied and lacked national guidance.¹

A large number of people arranged for a skull x ray to be taken in cases of suspected craniosynostosis, severe deformity or if symptoms were not resolving.

We reviewed the literature to determine the utility of a skull x ray in lambdoid synostosis in otherwise normal infants presenting with plagiocephaly.

A skull x ray that shows the entire length of the lambdoid suture to be patent rules out lambdoid synostosis.² Radiographic features such as obliteration or fusion of the suture and heaping up of bone are definitive of synostosis.³⁻⁴ However, the x ray may show deformed or depressed petrous bone, sclerosis along the suture line⁵ or indistinctness of the suture,⁴ all of which may represent synostosis.⁶

The definitive investigation for suspected craniosynostosis is a multidetector computed tomography scan with three-dimensional reconstruction. This requires high doses of radiation and therefore skull x rays are likely to continue to be the initial investigation in cases of clinical uncertainty.⁷

However, clinicians must note that interpretation of the skull x ray in these infants may not be straightforward and may not always give a clear answer.

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Competing interests: None declared.

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Breast feeding and the Baby Friendly Initiative: is the training of doctors being ignored?

Breast feeding is an unequalled way of providing ideal food for the healthy growth and development of infants. It is also an integral part of the reproductive process, with important implications for the health of mothers. As a global public health recommendation, infants should be exclusively breast fed for the first 6 months of life to achieve optimal growth, development and health.¹ To promote this, the Baby-Friendly

Hospital Initiative was launched in 1991 by Unicef and the World Health Organization and recommended 10 steps for successful breast feeding, the attainment of which would give the health establishment a baby-friendly status. Step 2 aims to "train all healthcare staff in the skills necessary to implement this policy".² Crucially, fulfilment of this criterion is met by training midwives, health visitors and nurses, and does not include doctors.

The level of training varies among different health professionals, with most midwives and health visitors undergoing a 2-3-day breast-feeding awareness course. Doctors need less extensive training, but they still require information to enable them to provide effective support for breast feeding. The lack of breast-feeding knowledge and skills in paediatric trainees has been previously commented on in the UK³ and elsewhere.⁴

We assessed the level of knowledge of paediatric trainees in this regard. A questionnaire was given via telephone to paediatric senior house officers working in all 14 neonatal units in Wales from November 2003 to January 2004; 77 of the 87 (88.5%) doctors responded.

Of the 77 doctors, 14 (18%) had not received any training related to breast feeding in their present job; interestingly, this lack of training was similar in those units that had achieved baby-friendly status as compared with those that had not. The training, where present, was mostly in the form of a lecture. In all, 58 (75%) of the trainees were aware that babies should be exclusively breast-fed for the first 4-6 months. Only 30 (39%) knew that mothers of babies in special care baby units needed to express breast milk at least 6-8 times per day, including at night. Only 44 doctors (57%) had any idea of the baby-friendly initiative.

We strongly urge hospital trusts and paediatric departments to encourage their training doctors to learn about breast feeding. In this endeavour, they may find the recently available teaching packs for paediatricians and general practitioners at www.babyfriendly.org.uk useful.

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doi: 10.1136/adc.2006.098277

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