We identified 120 episodes of procedural sedation for 24 indications, utilising eight agents in 26 different locations (table 1).

Mean patient age was 6.6 years (range 12 weeks to 19 years). Twenty two per cent of sedations were performed after hours. Neither medical nor nursing staff were present during 7% of sedations nor during 23% of recovery periods. Formal monitoring of any vital signs was performed in 72%. Only 11% of patients were fasted for 6 hours solids/2 hours liquids or longer. Non-pharmacological or psychological techniques were used in 39% of patients and 28% were physically restrained. Staff rated the quality of the sedations episodes as very satisfactory or satisfactory in 86%. Where restraint was required the quality of the sedation episode was rated as very satisfactory or satisfactory in 76% and unsatisfactory or very unsatisfactory in 24%. The procedures were completed successfully in 95%.

This hospital wide study indicates that procedural sedations occur frequently (estimated 2000 episodes/year) and with variable quality of care. Areas for improvement have become apparent. Unmonitored or parent or technician only sedations should be abolished. Sedations should be shifted from low frequency and remote locations to higher frequency settings. Requirements for pre-sedation assessment, personnel, monitoring, and recovery should be defined and embedded into an educational process.² Deeper sedation requires participation of trained senior medical or anaesthesia staff as it is associated with higher risk of sedation related adverse events.³ Non-pharmacological interventions should be increased⁴ and staff understanding of an "ideal sedation" in terms of restraint use should be reviewed. We suspect that our core findings might be similar in other institutions that also lack a comprehensive sedation programme.

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F E Babl

Emergency Department, Royal Children's Hospital and Murdoch Children's Research Institute, Melbourne, Australia

J Munro

Department of General Medicine, Royal Children's Hospital and Murdoch Children's Research Institute, Melbourne, Australia

G Kainey

Clinical Support Service, Royal Children's Hospital and Murdoch Children's Research Institute, Melbourne, Australia

G M Palmer

Department of Anaesthesia and Pain Management Service, Royal Children's Hospital and Murdoch Children's Research Institute, Melbourne, Australia

A Iser

Department of General Medicine, Royal Children's Hospital and Murdoch Children's Research Institute, Melbourne, Australia

Correspondence to: Dr F E Babl, Consultant in Emergency Medicine, Emergency Department, Royal Children's Hospital, Parkville, Victoria 3055, Australia; franz.babl@rch.org.au

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Cost minimisation of RSV prevention with palivizumab

An outpatient respiratory syncytial virus (RSV) prophylaxis programme has been provided in Glasgow since 1999. Initially only high risk neonates were included but subsequently patients with congenital heart disease, congenital lung abnormalities, and other complex histories have been offered prophylaxis. Early attempts to minimise drug wastage via a buddy system were unsuccessful, with only a 1.4% cost saving in 2003–04. During the 2004–05 RSV season we aimed to strictly coordinate the delivery of effective prophylaxis while minimising drug costs through patient cohorting and vial sharing.

Local referral criteria were agreed. Referring clinicians were contacted to encourage timely referral to a designated coordinator (SW). Standardised information letters were then sent to parents and general practitioners.

Breakthrough infections immediately prior to or following the second dose of palivizumab had occurred during the early years of our prophylaxis programme. We therefore administered the second dose after three weeks with subsequent doses prescribed at four weekly intervals.

Outpatient clinics were held in the Ambulatory Ward of the Royal Hospital for Sick Children, Glasgow. The start date was chosen to predate the appearance of RSV infection and to avoid the need to attend for subsequent doses on Christmas or New Year holidays. Three cohorts of between 20 and 30 infants attended on consecutive afternoons. Referrals to the coordinator continued throughout the RSV season as eligible babies were discharged home. These infants were grouped together and, where possible, joined an initial cohort for subsequent doses.

We calculated projected vial usage if every infant had been individually dosed and compared this with our actual usage identified from our pharmacy database.

Eighty six referrals were received prior to the start of the season. These were divided into three cohorts. By the end of the season 93 infants were receiving prophylaxis in Glasgow in eight cohorts. In total 356 doses were given to 114 patients. Four patients (4.4%) were hospitalised with RSV infection. None required intensive care. Total drug costs for the year were £220 847, representing a saving of 16% (table 1).

Our experience shows that it is possible to minimise the cost of palivizumab administration by large group cohorting. This allowed us to maximise the use of 100 mg vials in preference to the more expensive 50 mg vials (table 1). This does however require tight coordination and appropriate outpatient resources. A national consensus on patient selection would facilitate coordinated local administration and perhaps positively influence the cost-benefit analysis of palivizumab prophylaxis.

S Wills, J H Simpson, J Coultts
Queen Mother's Hospital, Glasgow, UK

Correspondence to: Dr J H Simpson, Paediatric Department, Queen Mother's Hospital, Glasgow, UK; judith.simpson@yorkhill.scot.nhs.uk

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Patient's consent for publication of case report: need for developing a universal consent form

A patient's consent for publication of case report is a contentious issue and difficulties in this context have been reported.^{1,2} One of the lesser recognised problems is the lack of a universal patient consent form. Thus, different journals may have their own patient consent forms; for example, the consent form of *The Lancet* is not acceptable to *Archives of Disease in Childhood*. This means that the patient has to sign another consent form should the manuscript be rejected by one journal. This requires a repeat visit by the patient to his doctor. Since many of the patients, especially those receiving treatment at tertiary care centres, live a long way away, the repeat visit may be delayed, or worse, may not materialise at all. An alternative is to obtain the signature on the consent form by mail. This, in our experience, is not a rewarding exercise, especially if the patient does not understand the significance of this exercise.

Another alternative is to ask the patient to sign the consent forms of multiple journals. However, this has the potential of causing unnecessary alarm for the patient and may

Table 1 Palivizumab wastage and monetary savings

	Usage if individually dosed	Actual usage	Savings with vial sharing
50 mg vials	154	52	102
100 mg vials	322	317	5
Total mg	39900 mg	34300 mg	5600 mg
Drug discarded	7255 mg	1730 mg	5495 mg
Total cost	£262 374	£220 847	£41 527

lead to refusal to sign the consent form(s). Hence, there is a need for developing a common consent form which is acceptable to all journals. A photocopied, scanned, or faxed copy of the same should be admissible at the time of submission. The original hard copy, if required, may be submitted after acceptance of manuscript. The international committee of medical journal editors should discuss this issue at an appropriate forum.

A K Saxena

Department of Radio Diagnosis and Imaging,
Postgraduate Institute of Medical Education and
Research, Chandigarh, India

B Ghai, J K Makkar

Department of Anaesthesia and Intensive Care,
Postgraduate Institute of Medical Education and
Research, Chandigarh, India

Correspondence to: Dr A K Saxena, Department of
Radio Diagnosis and Imaging, Postgraduate Institute
of Medical Education and Research, Chandigarh,
India 160012; fatakshay@yahoo.com

doi: 10.1136/adc.2006.101212

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BOOK REVIEWS

Obesity prevention and public health

Edited by David Crawford, Robert W Jeffery.
Oxford University Press, 2005, £49.50 (US\$90
(approx.)); (€70 (approx.)), hardback, pp 338.
ISBN 019856600X

Although you may read the title and think, "Yet another book about obesity", this book represents an important transition in obesity prevention and research. While it focuses on obesity in all age groups, I believe the book presents two overarching themes that are

applicable to children and adolescents. The first is that the obesity epidemic cannot be tackled solely by focusing on the individual. Instead, the individual must be viewed within the broader context of his/her neighbourhood, school, and community, and policy at the national level. This principal message is woven throughout the chapters, such as those on sociocultural factors in obesity, population approaches to healthy eating, and physical activity, and lessons learned from tobacco control.

The second message is that we all need to be advocates in tackling obesity, regardless of whether we are clinicians, researchers, policy-makers, or parents. This is highlighted within the final chapter by Schwarz and Brownell titled, "The need for courageous action to prevent obesity", which synthesises current evidence to construct a comprehensive

list of recommendations to reduce the prevalence of obesity. Their list includes the role of social change, policies to support the increase of healthy foods in schools and restrict advertising directed at children, and developing coalitions to increase the momentum for social movements. While industry and government policy has often focused on the individual and personal responsibility, Schwarz and Brownell emphasise the role of the environment. "For innovative action to occur, it is imperative that we move beyond the superficial knowledge that people are making bad choices and turn instead to environmental changes that permit and encourage healthy choices to occur" (p. 320). They also suggest that supporting change through local organisations as well as change in policy through legislation and regulation provide hope for the future.

This book presents an extensive summary of the evidence by an internationally renowned panel of experts on obesity. In three sections it provides an overview of obesity and its determinants, strategies to promote healthy eating and physical activity, and a range of novel approaches to tackling obesity. While it may not provide much new information for public health researchers in the field, it will challenge them to think about how their research can be applied and used to inform the development of interventions or policy. What can this book offer to clinicians who see children and families in their clinics? It will allow them to view clinical work, either treatment or prevention, as part of a comprehensive strategy to tackle obesity. This is illustrated in a chapter by Davison and Campbell on the role of families within obesity prevention. They review the literature about how parents' eating and physical activity/inactivity patterns influence children's health behaviours; however, they note that parents should also be viewed within the context of their community and government policy and the media. Davison and Campbell also include an extensive list of examples for how practitioners and policy makers can support parents to encourage a healthy lifestyle among their children. This book provides strong evidence for the importance of preventing obesity, especially in children, and the need for an interdisciplinary approach across health professionals, from clinicians to policy makers, to control this epidemic.

S S Hawkins

Paediatric neurology: theory and practice

Edited by Christos P Panteliadis, Rudolf Korinthenberg. New York: Thieme, 2005, €99.95 (£70 (approx.)); US\$125 (approx.), hardback, pp 973. ISBN 3131415614

It was Bertrand Russell who said that a stupid man's report of what a clever man says can never be accurate, because he unconsciously translates what he hears into something he understands. Therefore reviewing a book written by so

many distinguished neurologists poses a challenge. Added to this is the fact that paediatric neurology is a mystery for many—the more you read the less you seem to understand.

Will this book help?

The third edition of *Paediatric neurology* is intended by its editors to provide an up-to-date reference guide to child neurology, including the most current literature and recent advances. It is a multi-author text (n = 68) with contributions mainly from Greece, Germany, and the USA.

In attempting to assess the book, I have used it, as intended by the authors, as a reference guide in my day-to-day work as a registrar on a neurology firm. The book is in hardback form with almost 1000 pages, so definitely not a pocket-guide—rather a book for the departmental library or home office. It is set over 52 chapters, which would have benefited from being grouped into sections to aid the reader find the relevant chapter more quickly.

There are some excellent chapters, including those on the hypotonic infant, acute encephalopathies, and seizure disorders, which I found useful in the clinical setting and which deserve a wide audience. Many of the chapters are by experienced clinicians, giving the book a breadth of vision, but inevitably there are differences in management and approach which reflect the multinational authorship.

There is some surprising omissions—non-accidental head injury is covered only briefly, while autism and ADHD are not covered at all. The overall quality of the illustrations is disappointing and many seem to add little to the text. Some of the chapters have grammar and syntax problems, which the reader can overcome, but which should not have been present had the book been adequately proof-read and edited. It is however well referenced throughout, with many contemporary entries to 2004.

Does this book unravel the mystery that is paediatric neurology? Well, it certainly goes a long way, but ultimately it needs to be judged against its rivals and it is here that my enthusiasm wanes. There are many excellent contributions in this book but it did not gain my confidence as the *essential* reference for paediatric neurology questions. At £70 it offers good value for money but, in the end, I will save my money up and buy Aicardi—you may wish to do the same.

N A Harrower

Oxford desk reference: clinical genetics

Edited by Helen V Firth, Jane A Hurst, Judith G Hall (consulting editor). Oxford University Press, 2005, £49.95 (US\$90 (approx.)); €75 (approx.), hardback, PP 708. ISBN 0192628968

Atlas of genetic diagnosis and counseling

Edited by Harold Chen. New Jersey: Humana Press, 2005, £144.50 (US\$270 (approx.)); €210 (approx.), hardback, pp 1076. ISBN 1588296814