sound trials that would obtain conclusive evidence, the following steps need to be carried out:

1. Double-blind trials should be conducted against a treated arm with a standard pyrimethamine-sulfonamids scheme for 1 year.
2. In the setting of our new knowledge about the geographical restriction of genotypes of toxoplasma, these trials should be carried out in sites with a homogenous distribution of these genotypes.
3. A concerted work plan should be established between the groups of researchers in toxoplasmosis to decide which is the best new drug to be tested in this trial based on the *in vitro* and *in vivo* data.

Researchers in South America would like to carry out clinical trials, but we are sure that our institutional review boards would never accept an untreated arm. The results would be useful to Europe if we were able to identify new combinations of drugs that are more efficacious and with relevant effect even in mild clinical forms of the disease.

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Was “variations of reproductive development” considered?

The new intersex terminology scheme, based on disorders of sex development (DSD) and discussed in the consensus statement by Hughes *et al*,¹ seems to offer the following benefits:

1. It covers a wide range of intersex conditions without using the archaic and stigmatising hermaphrodite and male/female pseudo-hermaphrodite terms.
2. It should end the problem of usage of the term “intersex” by some clinicians to mean ambiguous genitalia (and being extrapolated by the media to mean sex identity problems in

all cases) when it in fact includes conditions such as complete androgen insensitivity syndrome and Swyer syndrome, with a totally female phenotype.

3. It should abolish the assumption, on the part of the uninformed, that all affected people are “between the two sexes”.

4. It should reduce the problem of people using nouns to label patients. (“She’s a male pseudo-hermaphrodite” or “She’s a genetic male”, as if her whole being/identity is governed by this).

5. It allows the inclusion of non-intersex XX–female conditions like Mayer-Rokitansky-Kuster-Hauser syndrome, which share some common features (such as absence of uterus/vagina) with XY–female intersex conditions

6. It provides a terminology which might be acceptable to clinicians and funding bodies, and which has fewer political/activism associations in the eyes of parents.

7. It possibly differentiates intersex from trans-sexuality more clearly (but there is no doubt that the trans community will try to annex the DSD term).

The downside could be:

1. The choice of the term “disorder” is bad news. One might say, in its defence, that DSD is merely an umbrella term, and that the name of an individual diagnosis would be used wherever possible, but DSD’s position at the top of the naming hierarchy makes it hard to ignore this term.

2. Some adults like the more sociopolitical, whole-person terms, and may ask why people who have been advocating a non-medicalising “proud to be intersex” philosophy over the past 10–15 years now seem to be advocating terms based on pathology.

3. Reduction to a three-letter acronym is possibly unfortunate as it allows the use of DSD as a cover-up term (to avoid having to say the word “disorder” or “sex”?)

4. There was a lack of wide consultation on the new scheme among international peer support groups.

On 8 August 2006, one of our UK members had her story published in the *Independent* newspaper, an account in which she uses the term intersex. When asked whether she knew that the term was likely to change to DSD (in clinical circles at least), she replied, “Disorders of... is horrible. Just adds to the sense that we are wrong. I like intersex.”

So the overall structure of the scheme seems to be a considerable advance on what has hitherto been available, although certain terms used in it seem to be retrograde in nature. Like Milton Diamond and Hazel Beh,² my first reaction was why not use “variations of sex development”, but then I learnt that “variations of sex development” is already in use for ventriculoseptal defect. Was “variations of reproductive development” considered, especially as many people might take issue with the notion that their sex is disordered, whereas they might accept that they have a variation in some aspects of their reproductive tract?

Another important issue discussed in Chicago is improved patient care. We have worked since the mid-1990s with selected clinicians from UK to promote a patient-centred, multi-disciplinary approach to intersex patient care of the sort recommended in the consensus statement. The first meeting to which we were invited to discuss this with clinicians in the University College London Hospital National Health Service Trust was

held on 6 August 1997, and the multi-disciplinary clinic there has been running successfully for several years now, with a high proportion of our members attending. So the recommended paradigm is already up and running in the UK.

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Exposure to latex in schools

Latex allergy poses considerable life-long risks to those affected. Latex allergy typically occurs in, but is not restricted to, those with frequent exposure to latex and with allergy cross-reactive foods (bananas, chestnuts, kiwis and avocados).¹ Recurrent exposure is often occupational—seen in healthcare workers and rubber industry workers—and is also seen in certain patient groups such as patients with spina bifida and patients who have undergone multiple surgical procedures.² Atopic individuals exposed to latex are at an increased risk of developing latex allergy compared with the general population.³ Exposure to powdered latex gloves seems to be a particularly important factor in sensitising susceptible individuals,³ and the powder in the gloves is detectable in the environment for several months after glove use ceases.

A 12-year-old atopic boy with a history of latex allergy developed more frequent reactions after beginning secondary school. This prompted us to survey all secondary schools in the Fingal area of North Dublin in relation to latex exposure, and in particular, glove use.

Of the 28 schools, 12 (43%) responded. Of these, 9 (75%) were using latex gloves, including 6 (50%) using powdered latex gloves. No other source of latex exposure was identified by the schools. None of the schools had undertaken a risk assessment in relation to glove usage. Reasons cited for the choice of gloves were: (1) they were the only gloves made available by the employer; (2) they were the only gloves available in the suppliers’ catalogue; and (3) comfort. The activities requiring glove use were science (biology and chemistry, home-economics, agricultural science, green school duties), waste recycling and first aid.

The main benefit of latex gloves over non-latex alternatives is improved protection against blood-borne infections.² Although this is clearly desirable to protect those undertaking first aid duties, it is not required for routine school practicals.

The unnecessary, routine use of latex gloves should be identified and discouraged through appropriate risk assessment.² Despite the relatively low response rate in our survey, even if all non-responding schools were not using latex gloves, a minimum of 21% of schools

are using powdered latex gloves. This means that substantial numbers of atopic children are unnecessarily being exposed to latex in its most allergenic form on a regular basis.

School boards of management are largely comprised of volunteers, and are overstretched by a large variety of demands. In the absence of occupational health support, few schools would have the expert knowledge to identify the risks associated with latex, particularly in the form of powdered gloves. Information regarding the risks of powdered gloves and details of suitable alternatives should be circulated to schools.

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Is the heat wave increasing the number of falls from open windows among children?

Head injury is a leading cause of death and disability in children and young people worldwide.^{1,2} The incidence of accidents and head injury among children increases during the summer months.^{3,4} During the warmer months of summer, when windows are often left open, the number of children who falls from windows increases dramatically. The exact incidence of falls from open windows among children in the United Kingdom is not known. Each year in the United States, 15–20 children <10 years of age die, and >4000 are treated in hospital emergency rooms for window fall-related injuries. In one study that involved >2000 children in a suburban trauma centre, it was found that over 40% of them were admitted as a result of falls, 11% of which were from windows. Most of the children who fell were between the ages of 0 and 4, and all were sent directly to the intensive care unit; 4% of the children died. Most window falls occur when children are unsupervised. The height and rate of the fall, force of impact and surface on which the child falls influence the severity of injuries.

Six children (four boys and two girls) from Leicestershire had a range of injuries, including a fractured skull, after falling from bedroom windows in the summer of 2006. This is an unusual cause for head injury among children and no similar incidents were recorded in the previous year. These accidents occurred in the month of July, which had some of the record-breaking temperatures of last year. The history from parents and carers of these children suggested that they had fallen out of open windows (5/6 from the first floor and 1/6 from

the ground floor window). In 5 children, the bed had been placed close to the window; in all cases the window was left open to counter the scorching heat. The age of the children ranged from 18 months to 5 years. All the children were developmentally normal before the incident. They fell out of open windows from a height of approximately 5–20 feet. All required admission to the paediatric intensive care unit and had altered levels of consciousness on presentation to the hospital. All required intubation and ventilation for 12–24 h, had to stay in the intensive care unit for 1–3 days and in hospital for 3–10 days. Five of the children had fractures, including fractures of long bones and clavicle, and multiple fractures of the skull. Two children had abnormal computed tomography or magnetic resonance imaging scans, which included subdural haematoma and cerebral contusion. All were treated symptomatically. Five children had a normal neurological examination on discharge from intensive care and hospital.

Window guard legislation enacted in New York City in 1976 dramatically reduced the number of window falls. In 2000, the US Consumer Product Safety Commission announced new safety standards for window guards that will help parents protect their children from window falls.⁵ Most accidents involving children can be prevented by increased awareness of child safety at home, improvement of the home environment and greater supervision. Simple measures such as fitting safety locks to windows (to stop them opening any wider than 10 cm/4 inches) as well as moving beds, particularly bunk beds, and furniture away from windows can help prevent further accidents.

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Water intoxication and the heat wave

In the UK, we are presently in the middle of a considerable heat wave, with July 2006 declared the UK's hottest month on record.¹ Both the Department of Health and NHS Direct have been quick to disseminate health advice,² particularly to parents and healthcare workers responsible for the care of children, about the dangers of exposure to heat and dehydration.

This advice has emphasised the need for adequate fluid intake, particularly that of water. Notably, parents have been encouraged to "give babies plenty of cooled boiled water throughout the day".³ Although we believe this to be a sound advice to parents in most situations, it is important for clinicians to be aware of the risks of water intoxication, especially in infants. Water intoxication in children is well described previously⁴ and is on the increase, if not reaching epidemic proportions, in the United States.⁵ It can cause considerable morbidity and mortality from hyponatraemia, brain swelling and seizures. Primarily associated with inappropriate dilution of formula feeds, bottled water has been described previously as a noteworthy cause.^{6,7} Children are at particular risk as it is thought that apart from immature renal function, infants have a powerful thirst drive, which may impede their ability to curb intake. Bhalla *et al.*⁸ reported four cases of hyponatraemic seizures in the UK that were secondary to excessive solute ingestion.

Being a paediatric intensive care retrieval service, we have recently dealt with previously normal hyponatraemic children presenting with abnormal neurology and seizures. A 1-year-old child presented with status epilepticus after a 2-day history of vomiting, during which hypotonic fluids were given. The child required intravenous lorazepam and one dose of rectal paraldehyde to terminate the seizure, and was intubated, ventilated and transferred to a regional paediatric intensive care unit. The concentration of serum sodium on attendance was 116 mmol/l. The child was subsequently fluid restricted for 48 h.

Although we have insufficient evidence at present to implicate water intoxication in the pathogenesis, we feel it is an issue that has not been considered in the current literature of the Department of Health. This situation also emphasises the importance of educating parents about the potential risks of this condition.

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