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.

Caroline Dore Geraghty, Mary T Keaghan
Immunology Department, Beaumont Hospital,
Beaumont, Dublin, Ireland

Correspondence to: Dr Caroline Dore Geraghty,
Immunology Department, Beaumont Hospital,
Beaumont, Dublin 9, Ireland; cariedg99@yahoo.co.uk

doi: 10.1136/adc.2006.107276

Competing interests: None declared.

References

- 1 Beezhold DH, Sussman GL, Liss GM, *et al.* Latex allergy can induce clinical reactions to specific foods. *Clin Exp Allergy* 1996;**26**:416–22.
- 2 Cullinan P, Brown R, Field A, *et al.* Position paper. Latex allergy. A position paper of the British society of Allergy and Clinical Immunology. *Clin Exp Allergy* 2003;**33**:1484–99.
- 3 Smedley J. Editorial. Occupational latex allergy: the magnitude of the problem and its prevention. *Clin Exp Allergy* 2000;**30**:458–60.

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.

N Hussain, L Mewasingh, J Gosalakal
Leicester Royal Infirmary, Leicester, UK

Correspondence to: Dr N Hussain, Leicester Royal Infirmary, University Hospital of Leicester NHS Trust, Leicester LE1 5WW, UK; dr_nahin@yahoo.com

doi: 10.1136/adc.2006.107219

Competing interests: None declared.

References

- 1 World Health Organization. *World health statistics annual*. Geneva: WHO, 1995.
- 2 Robertson LS. *Injury epidemiology*. New York: Oxford University Press, 1992.
- 3 Morrison A, Stone DH, Doraiswamy N, *et al.* Injury surveillance in an accident and emergency department: a year in the life of CHIRPP. *Arch Dis Child* 1999;**80**:533–6.
- 4 Parslow RC, Morris KP, Tasker RC, *et al.* Epidemiology of traumatic brain injury in children receiving intensive care in the UK. *Arch Dis Child* 2005;**90**:1182–7.
- 5 American Academy of Pediatrics: Committee on Injury and Poison Prevention. Falls from heights: windows, roofs and balconies. *Pediatrics* 2001;**107**:1188–91.

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.

R M Kayani, P Ramnarayan

Children's Acute Transport Service, Great Ormond Street Hospital, London, UK

Correspondence to: Dr R M Kayani, Children's Acute Transport Service, Great Ormond Street Hospital, London, UK; riazkayani@btinternet.com

doi: 10.1136/adc.2006.107599

Competing interests: None declared.

References

- 1 Meteorological Office Press Release. Record breaking weather. <http://www.met.gov.uk/corporate/pressoffice/2006/pr20060801.html> (accessed 13 Nov 2006).
- 2 Department of Health. 'Heatwave'—a guide to looking after yourself and others during hot weather. <http://www.dh.gov.uk/assetRoot/04/13/53/04/04135304.pdf> (accessed 13 Nov 2006).
- 3 Department of Health. How can I keep my baby safe during hot weather? <http://www.nhsdirect.nhs.uk/articles/article.aspx?ArticleId=1955> (accessed 13 Nov 2006).
- 4 Dugan S, Holliday MA. Water intoxication in two infants following the voluntary ingestion of excessive fluids. *Pediatrics* 1967;**39**:418–20.
- 5 Keating JP, Schears GJ, Dodge PR. Oral water intoxication in infants. An American epidemic. *Am J Dis Child* 1991;**145**:985–90.
- 6 Bruce RC, Kliegman RM. Hyponatremic seizures secondary to oral water intoxication in infancy:

association with commercial bottled drinking water. Review. *Pediatrics* 1997;100:E4.

7 Centers for Disease Control and Prevention.

Hyponatremic seizures among infants fed with commercial bottled drinking water—Wisconsin, 1993. *JAMA* 1994;272:996-7.

8 Bhalla P, Eaton FE, Coulter JBS, et al. Lesson of the week: hyponatraemic seizures and excessive intake of hypotonic fluids in young children. *BMJ* 1999;319:1554-7.

The HIV code

Confidentiality is an essential part of testing for HIV. The usual practice is of using a code to represent the patient's name. Commonly, this has included the date of birth. However, no definite guidelines are available to standardise the coding methods used in various situations. This has often led to confusion with results, a situation that is to be avoided at all costs, especially in an illness such as HIV.

With the increasing longevity of persons with HIV, it is essential to have a coding system that will stand the test of time. Difficulties have arisen with the manner in which the name is represented in the code and in the format in which the date is expressed. Some centres have further complicated the issue by asking patients to choose their own code. As the patient is advised not to choose his birthday or any easily identifiable number (ridiculous as birth dates are the usual identifier used by doctors), codes are chosen at random, and hence often forgotten. Those of us who have forgotten our automated teller machine card personal identification numbers will testify that this is a common occurrence.

The problem is compounded if the doctor forgets to enter the randomly chosen code in the patient's notes, something that happens more often in a busy clinic than most of us like to admit.

Using fictional situations, we illustrate the practically innumerable variations that are possible.

To list all the variations would take an entire journal. A few examples are listed.

Mary Smith, born on 2 June 2004

Possible codes are as follows:

(1) Name before the date, first name first, surname second, date as day/month/year

- MS 2604
- MS 262004
- MS 02062004
- MS 020604
- MS 6204
- MS 622004
- MS 060204
- MS 060204
- MS 0462
- MS 040602

(2) Name before the date, surname first, first name second, date as day/month/year and various other formats

- SM 2604
- SM 262004
- SM 02062004
- SM 020604
- SM 6204
- SM 622004
- SM 060204

- SM 060204
- SM 0462
- SM 040602

(3) Name after the date of birth, first name first, surname second, date as day/month/year and various other formats

- 2604 MS
- 262004 MS
- 02062004 MS
- 020604 MS
- 6204 MS
- 622004 MS
- 060204 MS
- 060204 MS
- 0462 MS

(4) Name after the date of birth, surname first, first name second, date as day/month/year and various other formats

- 6204 SM
- Etc...

(5) Mary Smith has a twin sister. Her name is Michelle Smith. Her code will be the same as above as they were both born on the same day.

(6) Checking the registration records in the city, there were 102 girls born on 2 June 2006. Follow-up showed that 13 of these girls had the following names:

- Samantha Masters
- Margaret Simmons
- Mallika Sundar
- Miranda Silas
- Sandra Mathew
- Melinda Sedak
- Etc...
- Their codes will be identical to Mary Smith's code.

(7) Mary Smith gets married to Thomas Jones and changes her name to Mary Smith-Jones. What will be the appropriate code for Mary Smith-Jones?

- MS-J 040602
- MJ 040602
- Etc...

(8) Mary Smith has a baby on 25 July 2030. It is a girl, and the parents cannot agree on a name. Until they do agree, it is decided the baby should remain as Baby of Mary Smith-Jones or Mary Smith-Jones's baby. What will be the appropriate code for the baby?

- B/O MSJ 240730
- MS BABY 240730

(9) Several months later, the baby is named Ava Delia Smith-Jones. What will be the appropriate code for the baby now?

- AS-J 240703
- ASJ 240703
- ADSJ 240703
- Of course, the laboratory has no way of knowing that B/O MSJ is the same as AS-J.

(10) Mary Smith's best friend is Charlene de Mille who was born on 8 May 2003. What will be the appropriate code for Charlene?

- CM 8503
- CD 8503
- CdM 8503

(11) Mary Smith joins the police force as a young woman and becomes an outspoken advocate of children's rights. After a police raid of a human trafficking operation, three unidentified boys aged around 5, 7 and 8 years are brought into the accident and emergency department. Their names and dates of birth are unknown. For identification purposes, they are given the names: John Doe 1, John Doe 2 and John Doe 3. What will be the appropriate codes for these John Does?

- JD-1 Unknown
- JD-1 date of arrival at A&E
- JD- approximate year of birth
- Months later, checking for the results, one finds many John Does all over the city. How does one know which one is which?

(12) Mary Smith is taking karate classes. Her tutor is Lee Wan Chuc. He was born on 1 January 1980. He insists that he does not have a surname. What will be the appropriate code for Mary Smith's tutor?

- LWC 1180
- CWL 1180
- LC 1180

(13) Mary Smith is interested in Indian dance and she has finally found an authentic Indian dance teacher. His name is CK Mitra. He was born on 10 February 1974. He explains his name as follows: C is for Candoth, which is the name of his ancestral home; K is Kurla, which is the hometown of his mother; his father's name (which is his surname) is Sripal, but Sripal does not figure in Mitra's name. What will be the appropriate code for her dance teacher?

- CM 10274
- CKM 10274

(14) Well into middle age, Mary Smith divorces Mr Jones. She converts to Buddhism and changes her name to Shanthi. What will be the appropriate code for Shanthi?

- S 2604
- No one will ever know that she is Mary Smith, who tested positive for AIDS 6 years ago.

Another example

And last, but not least, the artiste, formerly known as Prince, was born on 7 June 1958. What will be the appropriate code for him?

AFKAP 7568
7658
070658
07061958
and so on.

Surely, Da Vinci never had it so bad?

M A Sajeev

Sunnyside, 5th Avenue, Belleville, St Michael, Barbados;
kidsdoc@caribsurf.com

doi: 10.1136/adc.2006.107573