portosystemic shunt had not resulted in any amelioration. Four months after removal of a 1.7 kg heavy spleen, platelets were at 550 000/mm³ and all skin signs had disappeared. Even if it can be asserted that the thrombopenia is no real reason for concern, knowing that it has normalised is reassuring. We confirm improvement of pulmonary function and a positive effect on nutritional status, which was maintained even 5 years later. From the present article and our own results, it is clear that splenectomy can have many beneficial effects while of delaying the need for liver transplantation for several years. However, it should be performed only in highly controlled conditions, with provision for a rigorous follow-up and constant awareness of the danger of overwhelming sepsis.

Stephanie Van Biervliet, Eddy Robberecht
Ghent University Hospital, Ghent, Flanders, Belgium

Correspondence to: Dr S Van Biervliet, Ghent University Hospital, De Pintelaan 185, 9000 Ghent, Belgium; stephanie.vanbiervliet@ugent.be

doi: 10.1136/adc.2006.110197

Competing interests: None declared.

References

- 1 Linnane B, Oliver MR, Robinson PJ. Does splenectomy in cystic fibrosis related liver disease improve lung function and nutritional status? A case series. *Arch Dis Child* 2006;**91**:771–3.
- 2 Robberecht E, Van Biervliet S, Vanrenterghem K, et al. Outcome of total splenectomy with portosystemic shunt for massive splenomegaly and variceal bleeding in cystic fibrosis. *J Pediatr Surg* 2006;**41**:1561–5.

More blood tests in paracetamol overdose?

We read with interest the recent article in *Archives of Disease in Childhood* concerning paracetamol-induced hepatotoxicity,¹ and discussed it at the Journal Club of the Derbyshire Children's Hospital's. We found the management algorithm useful for knowing which patients we need to refer to a specialist unit. However, we felt that some clarification is needed regarding the issue of repeat blood tests in two situations.

1. In Management A (paracetamol level below the treatment line and an overdose <150 mg/kg), the authors suggest observation and repeat blood tests in 24 h. Our current practice, as guided by Toxbase (<http://www.spib.axl.co.uk/toxbaseindex.htm>), is not to do any further blood tests on children who do not require treatment. They stay in hospital to see Child and Adolescent Mental Health Services, and are often discharged before 24 h. The authors did not present any evidence for repeating blood tests in those not requiring N-acetylcysteine (NAC). Adopting this practice would increase our current admission times.

2. Management B suggested 8–12-hourly blood tests while on NAC. Again, our current practice is to perform blood tests at the end of the NAC, which is usually about 16 h later. Depending on these blood test results, we make the decision whether or not to continue the NAC. We are not sure whether to perform blood tests sooner on all patients, or on some patients, and whether this would change our management.

It would be helpful to know the evidence behind these issues.

Ruth Owen
Derbyshire Children's Hospital, Leicester, UK

Helen M Sammons

Correspondence to: Dr R Owen, Derbyshire Children's Hospital, Uttoxeter Road, Derby DE22 3NE, UK; ruth.owen@doctors.org.uk

Competing interests: None declared.

Reference

- 1 Mahadevan S, McKiernan P, Davies P, et al. Paracetamol induced hepatotoxicity. *Arch Dis Child* 2006;**91**:598–603.

Authors' response

The letter by Sanchez-Bayle *et al*¹ states that the administration of hypotonic saline to children with gastroenteritis is not, in their view, associated with an increased risk of hyponatraemia. This is in sharp contrast with our findings,^{2,3} and those of others, showing that the risk is real. Unfortunately, the data provided by Sanchez-Bayle are insufficient for analysis and we look forward to their findings being published in full.

On the other hand, we also concluded from our studies that any isotonic solution used should contain added glucose. In two studies of children with gastroenteritis (n = 154), we have documented a 4% rate of hypoglycaemia (blood glucose concentration <2.6 mmol/l) at presentation.^{2,3} In both studies, the hypoglycaemia responded to the 2.5% dextrose content of the intravenous fluid prescribed at either a slow or rapid rehydration rate. Much of the recent literature on isotonic versus hypotonic saline solutions for children ignores the need for glucose, and we welcome this focus.

Kristen A Neville, Charles F Verge,
Andrew R Rosenberg, Matthew W O'Meara,
Jan L Walker
Sydney Children's Hospital, Randwick, New South Wales, Australia

Correspondence to: Dr K A Neville, Sydney Children's Hospital, High St, Randwick, NSW 2031, Australia; kristen.neville@sesionhs.health.nsw.gov.au

Competing interests: None declared.

References

- 1 Sanchez-Bayle M, Alonso-Ojembarrena A, Cano-Fernandez J. Intravenous rehydration of children with gastroenteritis: which solution is better? *Arch Dis Child* 2006;**91**:716.
- 2 Neville KA, Verge CF, O'Meara MW, et al. High antidiuretic hormone levels and hyponatraemia in children with gastroenteritis. *Pediatrics* 2005;**116**:1401–7.
- 3 Neville KA, Verge CF, Rosenberg AR, et al. Isotonic is better than hypotonic saline for intravenous rehydration of children with gastroenteritis: a prospective randomised study. *Arch Dis Child* 2006;**91**:226–32.

Developmental assessment: practice makes perfect

Developmental assessment is an essential component of paediatrics, and is a key feature of the Member of Royal College of Paediatrics and Child Health (MRCPCH) clinical examination. All candidates have a child development station, which accounts for 10% of the total mark. The "Hints and Tips" section of the Royal College of Paediatrics and Child Health *Guide notes for candidates* document states "The

Table 1 Number of practice developmental assessments in preparation for examination

Number of practices	Candidates n (%)
0	16 (26%)
1	15 (25%)
2	15 (25%)
3	11 (18%)
5	3 (5%)
>10	1 (1.6%)

examiners are looking for an organised approach—and the best thing you can do, is to assess as many children as possible."¹

Candidates attending preparatory clinical courses held 2–3 weeks before the MRCPCH clinical examination sessions in February and June 2006 were asked how many times they had practised a developmental assessment of a child in preparation for their examination. Table 1 details the answers given by 61 candidates.

The results show that the candidates fail to understand that developmental assessment is a key component of the examination, and imply that these core skills are not being dealt with in current senior house officer training programmes. Three quarters of the candidates had practised no more than twice, with a quarter having performed no practice in child development assessments at all.

Developmental assessment should be considered a core competency in early paediatric training programmes. Candidates taking the MRCPCH clinical examination need to ensure that they use all available opportunities to practise assessing child development. It is also clear that good organisation and preparation are the key factors in passing clinical examinations.²

The restructuring of competency-based training and assessment, as a result of the modernising medical careers reforms,³ is an opportunity to increase developmental assessment training for paediatric trainees.

Robert E Klaber, Steven B Welch
Department of Paediatrics, Imperial College London (St Mary's Campus), Wright Fleming Institute, Norfolk Place, London, UK

Saul N Faust
University of Southampton, Highfield, London, UK

Correspondence to: Dr R E Klaber, Department of Paediatrics, Imperial College London (St Mary's Campus), Wright Fleming Institute, Norfolk Place, London W2 1PG, UK; bobklaber@doctors.org.uk

doi: 10.1136/adc.2006.109967

Competing interests: None.

References

- 1 Royal College of Paediatrics and Child Health. Exams/MRCPCH Clinical/Guide notes for candidates. www.rcpch.ac.uk/publications/examinations_documents/mrcpch_clinical_candidate_info230905.pdf (accessed 11 Dec 2006).
- 2 Stanley AG, Khan KM, Hussain W, et al. Disorganized junior doctors fail the MRCP (UK). *Med Teach* 2006;**28**:e40–2.
- 3 National Health Service. Modernising medical careers. <http://www.mmc.nhs.uk/pages/home> (accessed 11 Dec 2006).